



## INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE  
Please Print or Type

(GROUP) Labor Association of WI, Inc.		(EMPLOYER)		GROUP NO. 43274 If applicable, Local # _____	
EMPLOYEE LAST NAME	FIRST	M.I.		DATE OF BIRTH	
STREET ADDRESS	CITY	STATE		ZIP	
SOCIAL SECURITY NUMBER - -	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		TELEPHONE:		
EFFECTIVE DATE OF COVERAGE OR CHANGE:			CONTRACT TYPE REQUESTED <input type="checkbox"/> Single (S) <input type="checkbox"/> Family (F)		

### COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

#### PLEASE CHECK THE APPROPRIATE ACTION CODES FOR CHANGES

THIS CHANGE IS FOR: ☐ EMPLOYEE ☐ SPOUSE ☐ DEPENDENT(S)

TYPE OF CHANGE: ☐ NEW ENROLLMENT ☐ CHANGE OF ADDRESS ☐ NAME CHANGE ☐ REINSTATEMENT ☐ CHANGE TO COBRA  
☐ ISSUE NEW CARD ☐ CHANGE OF COVERAGE ☐ NAME CHANGE, FORMERLY \_\_\_\_\_

LAST NAME	FIRST NAME	INITIAL	M/F	DATE OF BIRTH	STUDENT (Y/N)
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

EMPLOYEE SIGNATURE: **X** \_\_\_\_\_ DATE: \_\_\_\_\_

**Return completed form to:** Labor Association of Wisconsin, Inc.  
N116 W16033 Main Street  
Germantown, WI 53022